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Draft country programme document**

Armenia

Summary

The Executive Director presents the draft country programme document for Armenia for discussion and comments. The Executive Board is requested to approve the aggregate indicative budget of $3,405,000 from regular resources, subject to the availability of funds, and $3,569,000 in other resources, subject to the availability of specific-purpose contributions, for the period 2005 to 2009.

* E/ICEF/2004/8.

** In accordance with Executive Board decision 2002/4 (E/ICEF/2002/8), the present document will be revised and posted on the UNICEF web site in October 2004, together with the summary results matrix. It will then be approved by the Executive Board at its first regular session of 2005.

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Basic data (2002 unless otherwise stated)	
Child population (millions, under 18 years)	0.8
U5MR (per 1,000 live births)	35
Underweight (%, moderate and severe, 2000)	3
Maternal mortality ratio (per 100,000 live births, 2001)	22
Primary school enrolment/attendance (% net, male/female, 2000)	69/70, 97/98
Primary school children reaching grade 5 (%, 2000)	100
Use of improved drinking water sources (%)	..
Adult HIV prevalence rate (%, 2001)	0.2
Child work (%, children 5-14 years-old)	..
GNI per capita (US$)	790
One-year-olds immunized against DPT3 (%)	94
One-year-olds immunized against measles (%)	91

The situation of children and women

1. In the last decade, Armenia has achieved significant economic growth, made progress in setting up democratic institutions and governing structures, and introduced comprehensive reforms affecting children. The Government has adopted the National Plan of Action (NPA) for the Protection of Children's Rights, 2004-2015; the Poverty Reduction Strategy Paper (PRSP), 2004-2015; and the Human Rights Defender Act; ratified the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, approved the National Strategy to Combat HIV/AIDS; and amended the Children's Rights Act in 2002 and 2003.

2. The impact of economic decline in the early transition years, however, has been so severe that at the end of 2003, approximately one half of the country's population was still poor, with one in seven persons unable to meet his/her basic survival needs. The Common Country Assessment (CCA) indicated that the combined effects of poverty, weak local governance, reduced access to basic social services and environmental degradation have contributed to the increasingly sharp cleavage between a few who are benefiting from economic growth and a majority who cannot find gainful employment. Income inequality remains high. Compounding these economic problems, Armenia is highly prone to natural disasters such as drought and earthquakes.

3. There has been a gradual and significant drop in living standards and income levels, and government expenditures on social services remain low. The Committee on the Rights of the Child has recommended that the Government establish a systematic assessment of the impact of budgetary allocations on the implementation of child rights, ensure the adequate distribution of resources at the national and local levels and prioritize budgetary allocations.

4. Children are most vulnerable to the consequences of extreme poverty than any other age or social group. A recent vulnerability assessment mapping exercise undertaken by the World Food Programme found that, in four *marzes**, 70-80 per cent of households had inadequate access to food and an energy intake that was 35 per cent below the national average of 2,200 kilo calories per person per day. In Gegharkunik *marz*, close to one half of the population has a poor diet, a factor that might explain the high prevalence of stunting among one third of children. The 2000 Armenia Demographic and Health Survey (DHS) reported that overall, 13 per cent of children under age five years are stunted. The prevalence of anaemia among children living in rural areas is twice that in urban areas. A 1998 national study, however, showed no vitamin A deficiency among children under five years of age.

5. Access to antenatal and postnatal health care remains low. Official data indicate that the rate of home deliveries and delivery complications increased from 1.4 per cent in 1990 to 2.6 per cent in 2000; the DHS noted about 9 per cent of births occur at home. Maternal deaths, primarily due to complications of pregnancy, abortion, and intra- and post-partum haemorrhages, increased from 20 to 29 per cent between 1996 and 2001. Household surveys indicated that the richest 20 per cent of the population use on average three times more health services than the poorest 20 per cent. Low morale of health-care staff, inadequate or inappropriate care by health workers and unresponsive mechanisms have affected the quality of services.

6. The under-five mortality rate (U5MR) declined from 51 per 1,000 live births in 1991-1995 to 39 in 1996-2000. The DHS attributed this decline largely to the Ministry of Health's 1994 initiative on case management of diarrhoea and acute respiratory infections (ARI), and breastfeeding promotion. Rural children have a higher U5MR (59 per 1,000 live births) than urban children (37).

7. A gap remains between the infant mortality rate (IMR) reported in official statistics and survey data. The difference lies in the continued use of the former Soviet definition of live births. Despite the country's decision in 1995 to adopt the World Health Organization (WHO) definition, data on infant birth and death events are still misreported. A recent study on the causes of infant mortality, carried out by UNICEF in collaboration with the Ministry of Health, argued that post-neonatal infant deaths and related illnesses could be prevented with higher standards of medical care. However, the study found that fewer than four in ten facilities that cater for births in the country had adequate infrastructure.

8. Armenia has sustained high immunization coverage for all antigens and was declared polio-free in 2002. There has been progress in the reduction of diphtheria and measles in the last two years. The rate of breastfeeding increased from 0.7 per cent in 1993 to 45 per cent in 2000 as a result of intensified training of service providers and public awareness campaigns on breast-feeding. The country is close to achieving universal salt iodization (USI) as the rate of household consumption of iodized salt reached 84 per cent. The law on USI and prevention of iodine deficiency disorders (IDD) passed the Parliament and has been submitted to the President for approval.

9. Surveillance results show that HIV in Armenia is spreading rapidly in high-risk groups, who now show a 5-per-cent prevalence rate, compared to the official

* Armenia is divided into 11 *marzes*, administrative units covering at least four to five regions.

overall prevalence rate of 0.2 per cent. The majority of the 251 HIV infections registered from 1998 to January 2004 are men, more than one half of them injecting drug users. One eighth of injecting drug users surveyed are women, often young. Behavioural surveillance data reveals that about 82 per cent of surveyed users began to use drugs between the ages of 15 and 29 years. More than one half of the sexually active young people interviewed indicated that they had more than one sexual partner during the last year. Cases of mother-to-child transmission of HIV have been reported.

10. Young people's awareness of HIV/AIDS and sexually transmitted infections (STIs) varies. Even among young people who are aware, most reports indicate that high-risk behaviours are still prevalent. A 2001 opinion poll noted that most young people say that they have insufficient information about HIV/AIDS and reproductive health. Although efforts to improve the situation are underway, including peer education, HIV/AIDS education in secondary and tertiary levels and voluntary counselling and testing, a systematic multisectoral response to the epidemic is still needed.

11. The Committee on the Rights of the Child has raised concerns that Armenia has not yet introduced legislative and other measures that sufficiently address the issue of violence against children. According to a 2003 study on violence, physical and psychological abuse against children occurs in both family and school settings. There remains a lack of motivation to report alleged violations to concerned authorities, despite the institutions having the authority and resources to address the problem. Care providers have limited capacities to provide counselling services to children and families at risk. Often, the extended family is not able to support children who are abused. The mechanisms for child protection and their relationship with other systems warrant a deeper analysis.

12. In the most socially disadvantaged communities, parents are often unable to register their children at birth due to administrative barriers and high transport costs. Many such families continue to rely on public care institutions as a form of social safety net. Over 11,000 children are enrolled in 53 boarding schools and 800 children are placed in seven state orphanages, although the majority of children in orphanages have at least one parent. The living conditions and nutritional status of children in these institutions are poor and not improving. Once a child is admitted to an institution, there is limited follow-up to re-integrate the child back into the family. After leaving these institutions, most children are at high risk of being trafficked, abused or in conflict with the law. Inadequate services, a lack of alternative community measures and the limited capacities of local authorities have sustained the numbers of children in institutions. The greatest number of children deprived of parental care are in Shirak and Lori *marzes*, which are still recovering from the devastating earthquake of 1988 and where unemployment rates are among the highest in the country.

13. The Committee on the Rights of the Child also expressed concern about the situation of a large number of refugees (240,000) from Azerbaijan who arrived in Armenia from 1988 to 1992 as a result of the conflict over Nagorno Karabakh. Refugees remain one of the most vulnerable groups in Armenia. Increased efforts to improve and facilitate their integration into Armenian society have been recommended. The displacement of the population as a result of both the conflict

and the earthquake has taken a toll on children belonging to socially disadvantaged families.

14. Almost all boys and girls go to school but absenteeism, repetition and drop-out rates in refugee and minority-populated areas are twice the average. About 25 per cent of school entrants nationwide do not reach grade 10. A UNICEF-assisted study noted that such children often face inflexible and rigid approaches used in schools. Most teachers are still to be fully oriented in the use of child-centred teaching methodologies. The majority of children with disabilities have limited access to basic education. Food and transportation form the largest part of the educational cost for a family, making the state-supported basic schooling inaccessible for children living in extreme poverty.

15. Close to 80 per cent of pre-school-age children are not able to attend pre-school. High fees, lack of learning materials, deteriorated conditions of facilities are among the reasons cited by parents. Alternative community-based services exist only in Yerevan and in five *marzes* with parental resource centres. A 2002 baseline study on early childhood development (ECD) revealed that there are substantial gaps in child-rearing practices and knowledge on ECD among community leaders, caregivers, parents and families.

Key results and lessons learned from previous cooperation, 2000-2004

Key results achieved

16. Armenia was certified polio-free in 2002. The country's high immunization coverage rates are the result of a partnership between UNICEF and the Government, with UNICEF having provided vaccines and immunization supplies, thus laying the foundations for the introduction of hepatitis B and measles/mumps/rubella vaccines. The Global Alliance for Vaccines and Immunization (GAVI) provided the funding for the hepatitis vaccine in 2002. The Ministry of Health has agreed to allocate funds to procure the annual requirement of one or two vaccines of the expanded programme on immunization (EPI) in 2004.

17. The rate of exclusive breastfeeding increased from 0.7 per cent in 1993 to 45 per cent in 2000. The Ministry of Health and the DHS found that promotion of breastfeeding contributed to lower IMR and decreased morbidity rates for ARI and diarrhoeal diseases, in combination with programmes to control diarrhoeal diseases and ARI and the Integrated Management of Childhood Illness.

18. Life-skills-based education has been integrated into the primary-school curriculum. Local research on the adequacy of ECD services helped to formulate national policies and programmes. Today, with support from the Government of the Netherlands, hundreds of parents and children benefit from ECD learning sessions provided at parental resource centres. Parents are able to use these sessions to articulate their views, make use of available learning resources and participate in learning activities facilitated by trained service providers. More than 2,000 caregivers have been oriented to child-focused pre-school teaching and care practices.

19. The country programme contributed to the development of a state strategy on de-institutionalization and appropriate standards of care for children in residential

care institutions. The Government has re-allocated some funds from the 2004 budget from orphanages to help 50 families reintegrate their children from orphanages back into the family. National regulations on the prevention, identification, registration, referral, treatment and rehabilitation of child abuse and neglect have been developed. Inclusive kindergartens and schools have been expanded and are now managed by programme partners and local and international non-governmental organizations (NGOs), together with the Ministry of Education and Science. The 2000-2004 country programme benefited from contributions from the Governments of Canada, the Netherlands and the United States; the European Commission; the National Committees for UNICEF of Austria, Germany, Japan and the United States; GAVI, Rotary International, the Millennium Armenian Children's Vaccine Fund and the Armenian Relief Society.

20. Members of the juvenile police and justice system, NGOs, care providers in residential institutions and young people's groups have gained better knowledge of child rights issues, with support from the European Commission.

Lessons learned

21. The original country programme, which had five sectoral programmes covering health and nutrition, child protection, education, advocacy and communication, and planning, monitoring and evaluation, was found to be too broad given the limited financial resources of the country programme. The 2002 mid-term review revised the programme's original targets and in particular called for a comprehensive approach to young people's health and development.

22. Although UNICEF is the main donor driving the effort, the Government's attempt to fund the procurement of one or two EPI vaccines in 2004 is a welcome move. However, if the gains made to date are to be sustainable, the draft law on immunization needs to be passed, a separate budget line for procurement of EPI vaccines and supplies needs to be incorporated in the state budget, and efforts to improve management capacities must be pursued.

23. Three main studies conducted from 2000 to 2003 by UNICEF, in cooperation with Save the Children and the Step by Step Foundation, point out that ECD services, where they exist, are costly, of low quality and are not flexible. Major gaps still exist in the content and quality of home-based child-rearing practices and knowledge of caregivers. In rural areas, parents have limited access to information on child development, with neighbours and relatives frequently referred to as information sources. The parental education initiative demonstrated a series of key actions needed for programme development. These included harnessing of local knowledge assets; facilitating the development of standards of care; and engaging local authorities to take the lead. The studies have also highlighted that the demand for knowledge may have increased but is still limited to where centres are located. Reaching the most vulnerable communities calls for the development of more community-specific approaches.

24. Because of a widely held belief that children are generally highly valued and cared for, it has been difficult to convince authorities that there is a need to address violence and abuse against children. Evidence-based advocacy, combined with efforts to reform policy, develop standards of care and improve referral mechanisms, have helped to change these views. The finding of a study documenting cases of child abuse, neglect and violence, supported by UNICEF and the Armenian Relief

Society, prompted a nationwide call to prevent child abuse and neglect. As a result, a national regulation was drafted on prevention, registration, referral and rehabilitation of child abuse and neglect. In particular, the study showed the importance of causal and capacity gap analyses for understanding "hidden" factors related to child abuse. It also showed that capacities of care providers to cope with stress need to be strengthened. Most care providers are not able to adequately deal with cases of child abuse largely due to limited referral mechanisms, absence of professional guidelines and the fragmentation of existing services.

The country programme, 2005-2009

Summary budget table

	(In thousands of United States dollars)		
Programme	*Regular resources*	*Other resources*	*Total*
Policy development and advocacy	700	550	1 250
Capacity development	1 550	2 124	3 674
Child, family and community participation	1 000	895	1 895
Cross-sectoral costs	155	--	155
Total	**3 405**	**3 569**	**6 974**

Preparation process

25. The CCA and the United Nations Development Assistance Framework (UNDAF), prepared in 2003, were integral to the formation of the new country programme. The UNDAF has one overarching goal, to contribute to the reduction of economic, social and political inequality, with four areas of cooperation: economic equity, social services, governance and environment. The preparation of the proposed programme of cooperation between UNICEF and the Government of Armenia for 2005-2009 started in November 2003 in consultation with the Government, NGOs, communities and young people. Both the UNDAF and the proposed UNICEF programme were endorsed at the Joint Strategy Meeting between United Nations agencies and government and other counterparts in March 2004.

Goals, key results and strategies

26. The country programme will focus on sustaining the progress made under the previous programme and scaling up good practices and approaches. It will contribute to the realization of children's rights to grow up healthy and well-nourished in a caring, nurturing and inclusive environment; to enjoy 10 years of quality and needs-based learning; and to feel safe and secure as young people.

27. The cooperation will focus on to the most socially disadvantaged groups, while ensuring the quality and standards of key interventions applied nationally. It will influence the development and adoption of appropriate policies; enhance the capacities of service providers to deliver quality services and care, and foster community and young people's participation. The programme will contribute to the achievement of the following key results: (a) children and women to have access to

health and nutrition programmes and quality care; (b) young children aged 0-6 years to receive appropriate psychosocial care from caregivers and be prepared for school; (c) children aged 6-16 years to complete 10 years of quality education; (d) children and young people to participate in decision-making that affects their lives; (e) young people aged 10-18 years to benefit from "youth-friendly" policies, programmes and services; (f) children at risk and children with disabilities to receive quality care; (g) at-risk children and children in institutions to have access to social and legal protection and rehabilitation, and be prevented from trafficking, abuse and neglect and from working in hazardous conditions; (h) children to be protected from environmental risks; and (i) parents, families, young people and communities to participate actively in the development of policies and the provision and monitoring of services for children and women.

28. UNICEF will use advocacy, capacity development and communication as key strategies to achieve those results. The country programme will be carried out at three levels: policy-making, the institutional level and the community. It will go to scale with national programmes and, together with other United Nations agencies, assist in facilitating the delivery of convergent services to the most socially disadvantaged groups and *marzes*; strengthen institutional capacities and mechanisms at national and subnational levels for maintaining progress and reaching out to the most socially disadvantaged groups; and enhance the capacities of children and young people, families and communities to exercise their rights. The geographic coverage of the programme will be national, with focus on five priority *marzes*.

Relationship to national priorities and the UNDAF

29. The PRSP reflects the Government's commitment to ensure high rates of economic growth and redistribute growth through social programmes aimed at the most socially disadvantaged groups. Armenia's UNDAF and NPA will support the achievement of the Millennium Development Goals and those of the PRSP. The UNICEF programme is designed to support implementation of the UNDAF and assist the implementation and monitoring of the NPA. UNICEF cooperation related to HIV/AIDS will be complemented by the work of the United Nations Population Fund to expand access to reproductive health services for socially disadvantaged groups. Child protection interventions will be linked to the efforts of the United Nations Development Programme to support the development of socially-oriented polices and improve governance.

Relationship to international priorities

30. The programme incorporates the five priorities of the UNICEF medium-term strategic plan, with emphasis on ECD, immunization "plus", child protection and fighting HIV/AIDS. Improving the quality of education and reducing absenteeism, repetition and drop-out rate among schoolchildren in refugee and minority-populated areas will be a focus in education and contribute to Education for All. The key results of the programme of cooperation will contribute to Armenia's commitments under the Millennium Development Goals to reduce mortality, promote healthy lives of children and women, address malnutrition and promote gender equality and women's empowerment.

Programme components

31. Through its three components on policy, capacity development and participation, the country programme will aim to sensitize communities, civil society and government authorities at all levels about rights-oriented processes. It will facilitate a better understanding of the causes of major problems faced by children and women, recognize their accountabilities and help take necessary actions and decisions. It will also enhance the generation of knowledge on the situation of children and women, thereby enhancing the capacity of civil society and others to draw attention to their claims, especially of those who are left out and at risk of exclusion. The programme aims to promote processes for community mobilization that will enable children and young people to participate meaningfully. Through communication, it will build commitment for rights-oriented processes and facilitate a better understanding and use of indigenous communication structures and networks.

Policy development and advocacy

32. The programme will focus on policy change and reform in three areas: health; child development and education; and child protection. In health, UNICEF will support the development of legal frameworks and national plans to contribute to sustainability of interventions, specifically focusing on immunization and vaccine independence, the adoption of the International Code of Marketing Breast-milk Substitutes and the achievement of USI. New UNICEF/WHO strategies and protocols on maternal and child health (MCH) and a unified system for birth and infant death registration will be adopted by all concerned agencies. Policies will be adopted on voluntary counselling and testing and confidentiality related to HIV/AIDS and young people, and on early identification and prevention of childhood disabilities.

33. In child development and education, UNICEF will support advocacy for policy and training of teachers and specialists. By 2005, a policy framework will be established for rapid expansion of integrated ECD services. By the end of the programme cycle, the number of inclusive kindergartens will be expanded from 18 to 30; care for children with disabilities will be part of the ECD standards of care; and child-centred, skills-based and needs-based teaching methods and learning will be incorporated into the education reform package. Guidelines on student participation in school councils and standards for "child-friendly" schools will be adopted.

34. Support to legal and administrative reforms in child protection will ensure that by 2009, national and local authorities will have strengthened skills in monitoring the implementation of the NPA. Also by 2009, policies and implementing guidelines will be in place in support of families at risk for prevention of institutionalization; establishment of alternative services; child abuse and neglect; child labour; juvenile justice administration; and early identification of childhood disability. Child protection bodies will be established at *marz* and municipal levels.

Capacity development

35. The programme will focus on enhancing capacities in the above-mentioned areas of health, child development and education, and child protection, including emergency preparedness. In health and nutrition, it will support the adoption and use

of guidelines and protocols on MCH, focusing on safe injection; the delivery of vaccines and sustained availability of immunization supplies; prevention of mother-to-child transmission of HIV; USI; reducing IMR; and breastfeeding promotion and the adoption of the International Code on Marketing of Breast-milk Substitutes. Health care providers will have increased knowledge and improved skills to deliver quality MCH services, including the identification and treatment of child abuse cases. Sustainable plans addressing micronutrient deficiencies will be in place, with service providers able to identify them and promote appropriate nutrition practices. A strengthened monitoring and surveillance system for health and nutrition will be in place.

36. In child development and education, the programme will, by 2006, operationalize an integrated approach to ECD in all 11 *marzes* at the community level. By 2009, at least 60 per cent of caregivers in five *marzes* will correctly provide psychosocial stimulation and caring practices to pre-school-age children. Mechanisms for monitoring school drop-outs and chronic absenteeism of children from vulnerable families will be strengthened. An increased number of teachers and principals in resource schools in all 11 *marzes* will have increased knowledge and skills on quality learning. Child-centred and interactive teaching will be introduced in pre- and in-service training programmes. At least 60 per cent of teachers and principals in five *marzes* will have increased knowledge and skills to provide an enabling environment for learning for children of minorities, refugees, internally displace persons (IDPs) and children with disabilities. Finally, the programme will ensure that children of refugees, minorities, IDPs and children with disabilities in the same five *marzes* use age-appropriate and culturally-sensitive learning materials.

37. In child protection, service providers and care givers at national and subnational levels will, by 2009, use improved standards of care for children at risk. By 2009, children at risk and children with disabilities in five *marzes* will be identified early and provided with legal, psychosocial, health and rehabilitation services. Also by 2009, professional and performance standards for all staff working with at-risk children will be in place. Local authorities in the same five *marzes* will be able to find alternatives for at-risk children from within their communities. Care providers will be able to provide adequate and appropriate care and protection to children in emergency situations, particularly for those deprived of parental care.

Child, family and community participation

38. By supporting and facilitating the use of community-based and participatory methodologies, the programme will enable communities to use tools and methods to identify and act on problems in the areas of health and nutrition, child development and education, and child protection. It will also aim to strengthen the participation of young people. In health and nutrition, at least 60 per cent of parents and caregivers in all 11 *marzes* will have increased awareness of their rights to basic health services, and be able to recognize common childhood illnesses and apply growth and development monitoring practices. Parents and caregivers will know about and understand the importance of immunization and iron deficiency anaemia and prevention of IDD. To help achieve these results, UNICEF will support community-initiated activities, training programmes and the adaptation of proven methodologies to the Armenian context.

39. In child development and education, community members and caregivers in five *marzes* will be able to provide psychosocial stimulation and caring practices to pre-school-age children. At least 60 per cent of villages in five *marzes* will contribute to the maintenance and operation of comprehensive ECD services. Children and young people will be able to express their views in school councils and settings outside of school.

40. In child protection, local authorities in five *marzes* will facilitate and support the inclusion of vulnerable families in social protection programmes. Civil society organizations (CSOs) will have increased knowledge and skills of standards of care and policies and improved skills to work with children at risk. NGOs will also monitor the protection of rights of at-risk children and will be able to report back on violations to child protection bodies and national and local authorities. Vulnerable families and children will be aware of, and be able to access and participate in, alternative services of care in their communities. Parents, children and young people will be better informed of their rights, and of issues related to violation of these rights such as domestic violence and human trafficking.

41. In the area of adolescent health and development, the programme will increase young people's access to information and skills so that they can protect themselves from STIs and HIV/AIDS and identify situations that place them at risk. At least 50 per cent of young people aged 10-18 years in all 11 *marzes* will have increased knowledge of STIs and HIV/AIDS, and will able to use "youth-friendly" services and attend life-skills based education. By 2005, a situation analysis on especially vulnerable young people will be completed and plans of action developed. By 2009, mechanisms for outreach to these young people will be in place and at least 10 per cent of them will have the knowledge and skills to work as peer outreach workers within their own communities.

42. The country programme will have a strong communication component to support all the above interventions. It will facilitate the putting in place and development of venues and spaces for dialogue between CSOs and national and local authorities on NPA implementation. It will enable families, communities and children in all 11 *marzes* to know how to refer child rights violations to child protection bodies. Parents and caregivers will know the requirements of, and nearest places for, birth registration. All vulnerable families and children in five *marzes* will have increased knowledge and skills concerning their right to protection. Communities will be increasingly involved in dialogue on issues affecting children and women.

43. **Cross-sectoral costs** will cover basic operational costs that directly support the country programme, including support staff and technical assistance that provides cross-cutting services for programmes.

Major partnerships

44. UNICEF will collaborate with all United Nations agencies in Armenia through the UNDAF. In child protection, partnerships will be sustained with the European Commission, the Organization for Security and Co-operation in Europe and the International Organization for Migration. Collaboration with the World Bank will continue on the implementation of child-centred and life-skills-based education. UNICEF will maintain partnerships with the United States Agency for International Development in the areas of health and nutrition and in the conduct of the next

DHS. The mobilization of resources from Armenian organizations for supporting various projects will be pursued. The other major partners of the cooperation will include GAVI, World Vision, *Medicins Sans Frontières*, *Douleurs Sans Frontières*, Save the Children and other international and national NGOs, CSOs, media and young people's organizations.

Monitoring, evaluation and programme management

45. Monitoring and evaluation activities will be coordinated through an integrated monitoring and evaluation plan. The UNICEF programme will assess progress and monitor results based on a set of key indicators that will include: (a) the proportion of children with access to child-centred and life-skills-based education; (b) the percentage of children of refugees, IDPs, minorities and children with disabilities enrolled in school; (c) the percentage of children deprived of parental care in state orphanages; (d) the number of children at risk, children with disabilities and abused children receiving psychological, legal, health and rehabilitation services; (e) the percentage of children with access to integrated ECD services; (f) IMR and U5MR; (g) immunization coverage; (h) the rate of consumption of iodized salt; and (i) the proportion of adolescents with access to "youth-friendly" services and life-skills education, including knowledge about HIV prevention. The programme will be monitored through quarterly and annual programme reviews, with monthly financial monitoring. UNICEF will also support the establishment of the *DevInfo* system with the National Statistics Service as a major partner. UNICEF and other United Nations agencies will track UNDAF baseline data at central and local levels through the National Social Monitoring System, being established under the National Statistics Service.

46. The Ministry of Foreign Affairs will oversee the implementation of the country programme, which will be carried out by the Ministries of Health, Education and Science, Labour and Social Issues, Justice, and Culture and Youth Affairs, the police, regional governments, the National Assembly and the National Statistics Service. UNICEF will work closely with other United Nations agencies through the UNDAF coordination unit that will be established. It will support the evaluation of the UNDAF in 2008, in collaboration with other United Nations agencies, the Government and national partners. The mid-term review of the programme will be conducted in 2007 and the results will be used to make any programmatic adjustments.